14 August 2019

Nick Jones
Senior Reporter
NZ Herald

E-mail: nicholas.jones@nzherald.co.nz

Dear Mr Jones,

Official Information Act (1982) Request

I write in response to your Official Information Act request dated 31 July 2019. You requested the following information:

- **Since September 1 2018, the number of serious adverse events related to maternity and birthing services and the number of suspected/ possible or yet to be investigated serious adverse events related to maternity and birthing services**
  - *(i.e events reported as possibly serious adverse events, but that haven't been confirmed as such yet).*

- **For each event, please provide a summary of what happened (including whether the baby died or was stillborn), findings (including any linked to resource concerns), recommendations and follow-up actions.**

As you are aware, each year all DHBs report any Serious Incidents (Severity Assessment Code - SAC 1 & 2) via an Adverse Event Brief (AEB), to the Health Quality and Safety Commission (HQSC). We note the analysis and reporting by the HQSC on all Serious Adverse Event from across NZ DHBs, and that CM Health data is consistent, and reflective of our service size and efforts to encourage open disclosure.

- https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/3580/

We provide information throughout the year of these serious adverse events, as they are identified, via reporting from the Clinical Governance Group to the Hospital Advisory Committee of the CMDHB board. This report notes all incidents by clinical division that have been reviewed by the Adverse Events Operational Group and reported to the HQSC as *potentially* meeting SAC 1 or 2 criteria. These reports to the CMDHB Board are publicly available via our website.

- https://countiesmanukau.health.nz/about-us/governance/board-and-committees/

In addition to this notification, any serious incident will have a full internal investigation commenced, and following this investigation, incidents severity rating may change.

These existing reports to by our Clinical Governance Group identify two such incidents in Women's Health services for the period from 1 September 2018 to July 2019. In both cases, the investigations into the incident continue. We note that these two incidents are in the context of a total of 57 Serious Incidents reported in the year, across all DHB clinical divisions. Like other DHBs, this level of information on our serious adverse events is already publicly available.

- One incident occurred in April 2019, and resulted in an intrauterine death (being a loss at, or after the 20th week of gestation), and,
- One incident occurred in June 2019, related to a retained swab in surgery.

We do not believe it is appropriate to provide more detail on these incidents at this time. Information on all completed serious incident investigations is published annually (in December), including summary details of each incident, summary investigation findings and any recommendations. This annual release of information occurs with the consent of the affected patients, and ensures that we protect the privacy of all individuals involved.

We do not believe the public interest in these matters outweighs the high privacy interests involved, particularly given the small number of cases, and our wish to maintain the ability for our staff to fairly participate in these investigation processes, and providing relevant information in confidence.

We are therefore declining this element of your request, under Section 9(2)(a) of the Act – to protect the privacy of natural persons. We believe the public interest is met in understanding that a full investigation of these types of incidents does occur, any recommendations are prioritised, information is shared with other agencies and investigations, and that summary information is released as part of an annual reporting cycle.

We would be disappointed if you chose to report on two incidents in isolation of the full report due for publication in December 2019. Doing so would diminish the ability of the public to consider the full and proper context and understanding of these events.

As we have previously stated in recent responses to you on this matter, the intention of these serious incident investigations and reports is to encourage an open culture, to learn from what happens, and to put in place systems to reduce the potential of recurrence, alongside other relevant independent external review and investigation processes, such as the Health and Disability Commissioner and Coronial process. The purpose of reviewing these events is to determine the underlying cause(s) of the event, to reduce the likelihood of such events occurring again. The intention of reporting adverse event incidents is not punitive. Serious adverse events reviews are undertaken according to the following principles:

- Establish the facts: what happened, to whom, where, how and why,
- To look for improvements in the system of care, rather than apportion blame to individuals,
- To establish how recurrence may be reduced or eliminated,
- To formulate recommendations and an action plan,
- To provide a report as a record of the review process,
- To provide a means of sharing learning from the incident.

We remain in contact with affected families throughout the investigation processes. In many cases, they continue to receive clinical care and support/ assistance from our clinicians. For events in Women's Health, the woman (and her whaanau/ family) are involved in our deliberations, and through our perinatal mortality co-ordinator (senior midwife) and/or the Clinical Quality and Risk Manager, are kept informed of progress of the investigation.

I trust this information satisfactorily answers your query. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive Officer
Counties Manukau Health